

**MIDLANDS ORTHOPAEDICS, P.A.**  
**RELEASE OF MEDICAL INFORMATION PROTOCOL**

Complete the Authorization for Release of Medical Information form in its entirety

Mail the completed form to:

Or fax to: 803.933.6710

Midlands Orthopaedics, P.A.  
On-Site HealthPort Representative  
1910 Blanding Street  
Columbia, SC 29201

The form may also be dropped off at either of our two locations.

Allow **seven to ten business days** for the request to be processed.

You will be billed directly by Healthport for the copying of your medical records as outlined below:

\$.65 per page for pages 1-25

\$.50 per page for pages 26-100 with a cap of \$25.00

\$.15 per page for pages over 100

Any questions concerning your invoice should be directed to HealthPort at 1.800.464.0035.

Any questions concerning the status of your request should be directed to 803.933.6175 or [healthport@midlandsortho.com](mailto:healthport@midlandsortho.com).

**MIDLANDS ORTHOPAEDICS, P. A.**  
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Print Patient's Full Name \_\_\_\_\_ Birth Date (Mo/Day/Yr) \_\_\_\_\_

Street Address \_\_\_\_\_ Social Security Number \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_ Phone (Home) \_\_\_\_\_

At the request of the individual, I \_\_\_\_\_, do hereby authorize **MOPA** to release:  
(Patient's Name)

**DATES OF SERVICE:** \_\_\_\_\_

<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> PATHOLOGY REPORTS	<input type="checkbox"/> EMERGENCY REPORTS
<input type="checkbox"/> HISTORY & PHYSICAL	<input type="checkbox"/> LABORATORY REPORTS	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> PROGRESS NOTES	<input type="checkbox"/> RADIOLOGY REPORTS	_____
<input type="checkbox"/> OPERATIVE NOTES	<input type="checkbox"/> ECG/EEG/CARIAC CATH	_____

I do  I do not authorize the release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

**RELEASE RECORDS TO:** \_\_\_\_\_

Name of Company/Agency/Facility/Person

Street Address

City, State, Zip Code

**PURPOSE OF DISCLOSURE:**

<input type="checkbox"/> REFERRAL TO SPECIALIST	<input type="checkbox"/> INSURANCE	<input type="checkbox"/> WORKERS COMP	<input type="checkbox"/> CHANGE OF DOCTOR
<input type="checkbox"/> DISABILITY DETERMINATION	<input type="checkbox"/> PERSONAL	<input type="checkbox"/> CONTINUING CARE	<input type="checkbox"/> LEGAL INVESTIGATION

OTHER (SPECIFY): \_\_\_\_\_

**Please provide a current telephone number in the event we need to contact you:** \_\_\_\_\_

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of Individual or Guardian or  
Personal Representative of patient's estate

Date

**NOTE:** There will be a charge for a personal copy or the permanent transfer of your records. HealthPort has been contracted to provide this service and will invoice you directly.

**MEDICAL INFORMATION RELEASED BY HEALTHPORT:**

<input type="checkbox"/> ENTIRE	<input type="checkbox"/> LAB	<input type="checkbox"/> EKG	_____
<input type="checkbox"/> DS	<input type="checkbox"/> EKG	<input type="checkbox"/> IMMUNE	ROI SPECIALIST
<input type="checkbox"/> OP	<input type="checkbox"/> X-RAY	<input type="checkbox"/> OTHER _____	_____
<input type="checkbox"/> HP	<input type="checkbox"/> PATH	_____	DATE

NUMBER OF PAGES \_\_\_\_\_